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DEPARTMENT OF JUSTICE AND FEDERAL TRADE COMMISSION ISSUE REPORT ON COMPETITION AND HEALTH CARE

Report Reviews the Role of Competition, Provides Recommendations to Improve the Balance Between Competition and Regulation in Health Care

WASHINGTON, D.C. – The Department of Justice (DOJ) and the Federal Trade Commission (FTC) today issued a joint report, *Improving Health Care: A Dose of Competition*, to inform consumers, businesses, and policy makers on a range of issues affecting the cost, quality, and accessibility of health care. Culminating a two-year project, the report reviews the role of competition and provides recommendations to improve the balance between competition and regulation in health care. The report provides significant recommendations and observations on a variety of topics, including the availability of information regarding the price and quality of health care services; cross-subsidies; physician collective bargaining; insurance mandates; hospital merger analysis; managed care organizations' bargaining power; and hospital group purchasing organizations.

"Health care is a $1.6 trillion industry that accounted for 14 percent of GDP in 2002. This report is the first comprehensive review of how competition and antitrust enforcement can be enhanced to produce the health care that consumers want," said R. Hewitt Pate, Assistant Attorney General for the Department of Justice's Antitrust Division. "Health care is an industry that can benefit from continued vigorous enforcement of the antitrust laws."

The report is based on 27 days of DOJ/FTC Joint Hearings on Health Care and Competition Law and Policy, held from February through October 2003; an FTC-sponsored workshop in September 2002; and independent research. The hearings gathered testimony and written comments from more than 300 participants, including representatives of various provider groups, insurers, employers, lawyers, patient advocates, and leading scholars on subjects ranging from antitrust and economics to health care quality and informed consent. Almost 6,000 pages of transcripts of the hearings and workshop and all written submissions are available on the DOJ's and FTC's website.

"Healthy competition equals healthy consumers. Consumers want high-quality, affordable, accessible health care, and the challenge of providing it requires new strategies," said FTC Chairman Timothy J. Muris. "Vigorous competition promotes the delivery of high-quality, cost-effective health care. This report provides guideposts for policy makers who want to ensure access to quality care and help consumers make informed choices."

The American free-market system is built on the premise that open competition and consumer choice maximize consumer welfare – even when complex products and services such as health care are involved. The DOJ and the FTC play an important role in safeguarding the free-market system from anticompetitive conduct by bringing enforcement actions against parties who violate antitrust and consumer protection laws. The report notes, however, that competition cannot solve all of the problems facing American health care. The report identifies prerequisites to effective competition, and provides concrete recommendations to improve the performance of the health care marketplace.

The recommendations in the report include the following:

1. Private payors, governments, and providers should continue experiments to improve incentives for providers to lower costs and enhance quality and for consumers to seek lower prices and better quality. Therefore, private payors, governments, and providers should improve measures of price and quality, give consumers more information on prices and quality in ways that they find useful and relevant, give consumers greater incentives to use such information, and align the interests of providers and consumers.

2. States should consider the following steps to decrease barriers to entry into provider markets:

    a. Reconsider whether Certificate of Need Programs best serve their citizens' health care needs. On balance, the DOJ and the FTC believe that such programs are not successful in containing health care costs, and they pose serious anticompetitive risks that usually outweigh their purported economic benefits;
    b. Consider broadening the membership of state licensing boards, as boards with broader membership could be less likely to limit competition; and
    c. Consider implementing uniform licensing standards to reduce barriers to telemedicine and competition from out-of-state providers.

3. Governments should reexamine the role of subsidies in health care markets in light of their inefficiencies and the potential to distort competition. Health care markets have numerous cross subsidies and indirect subsidies. Competitive markets compete away the higher prices and profits needed to sustain such subsidies. Competition cannot provide resources to those who lack them, and it does not work well when providers are expected to use higher profits in certain areas to cross-subsidize uncompensated care. In general, it is more efficient to provide subsidies directly to those who should receive them to ensure transparency.

4. Governments should not enact legislation to permit independent physicians to bargain collectively. Physician collective bargaining leads to higher prices and is unlikely to result in higher-quality care. There are numerous ways in which independent physicians can work together to improve quality without violating the antitrust laws.

5. States should consider the potential costs and benefits of regulating pharmacy benefit manager (PBM) transparency. In general, vigorous competition, rather than regulation, in the marketplace for PBMs is more likely to arrive at an optimal level of transparency. Just as competitive forces encourage PBMs to offer their best price and service combinations to health plan sponsors to gain access to subscribers, competition should also encourage disclosure of the information that health plan sponsors require to decide which PBM to contract.

6. Governments should reconsider whether current mandates best serve their citizens' health care needs. When deciding whether to mandate particular benefits, governments should

consider that mandates are likely to reduce competition, restrict consumer choice, raise the cost of health insurance, and increase the number of uninsured Americans.

The report also offers the agencies' perspective on a number of current antitrust enforcement issues in health care. The agencies' observations include the following:

- Payment for performance (P4P) arrangements among a group of physicians may constitute a form of financial risk-sharing. (Chapter 2)

- The determination of whether a physician network joint venture is clinically integrated depends on all the facts and circumstances. This inquiry may be aided, in some circumstances, by considering a number of questions, such as the goals of the joint venture, the likelihood those goals will be met, and the nexus between joint contracting and the attainment of those goals. (Chapter 2)

- The "hypothetical monopolist" test of the Merger Guidelines should be used to define geographic markets in hospital merger cases. To date, the agencies' experience and research indicate that the Elzinga-Hogarty test is not valid or reliable in defining geographic markets in hospital merger cases. The limitations and difficulties of conducting a proper critical loss analysis should be considered fully if this method is used to define a hospital geographic market. The types of evidence used in all merger cases – such as strategic planning documents of the merging parties and customer testimony and documents – should be used by the courts to help delineate relevant geographic markets in hospital merger cases. (Chapter 4)

- Hospital merger analysis should not be affected by a hospital's institutional status (i.e. nonprofit v. for-profit). (Chapter 4)

- The resolution of hospital merger challenges through community commitments generally should be disfavored. (Chapter 4)

- The safety zone provision of Statement 7 of the *DOJ and FTC Statements of Antitrust Enforcement Policy in Health Care* does not protect anticompetitive contracting practices of group purchasing organizations (GPOs). (Chapter 4)

- The available evidence does not indicate that there is a monopsony power problem in most health care markets. In any event, countervailing power is not an effective response to disparities in bargaining power between payors and providers. (Chapter 6)

- Private parties should not engage in anticompetitive conduct in responding to marketplace developments. (Chapters 2, 4, and 6)

The report addresses a wide range of topics, including consumer-driven health care, hospital mergers, quality ratings of hospitals and physicians, payment mechanisms for health care services, group purchasing organizations, mandated benefits, certificate of need regulations, licensure, allied health professionals, pharmaceutical pricing, pharmaceutical benefit managers, single-specialty hospitals, buying power in health care markets, and clinical and financial integration.

Copies of the report can be found on the Department of Justice's website at:

www.usdoj.gov/atr

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